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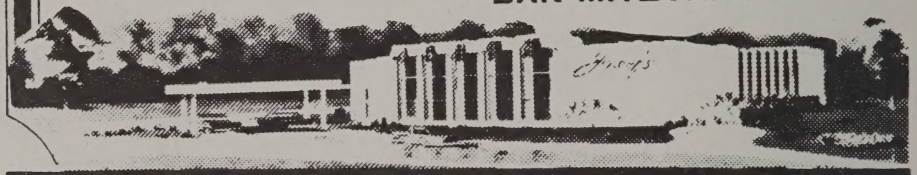

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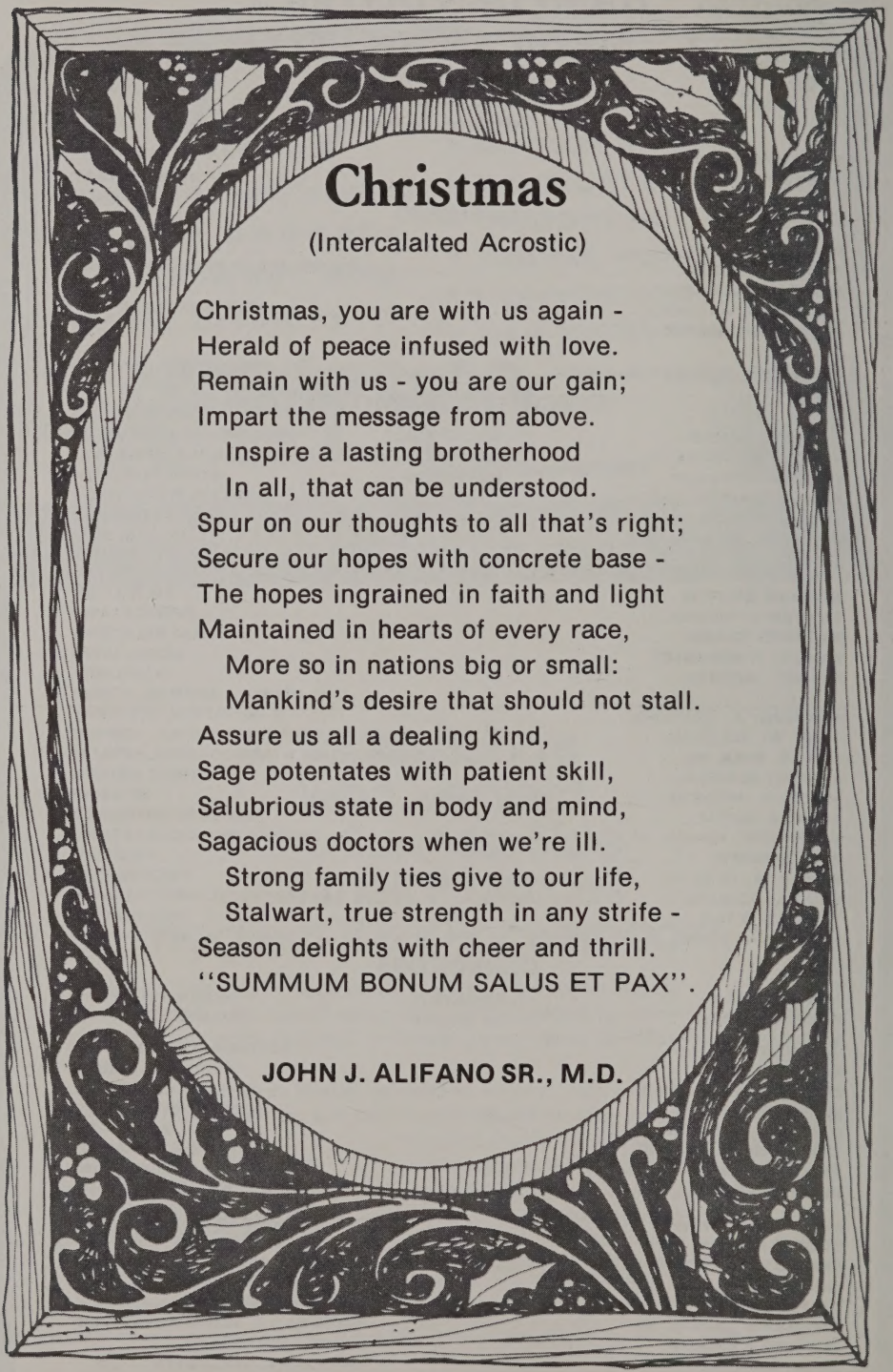

Christmas

(Intercalalted Acrostic)

Christmas, you are with us again -
Herald of peace infused with love.
Remain with us - you are our gain;
Impart the message from above.
  Inspire a lasting brotherhood
  In all, that can be understood.
Spur on our thoughts to all that's right;
Secure our hopes with concrete base -
The hopes ingrained in faith and light
Maintained in hearts of every race,
  More so in nations big or small:
  Mankind's desire that should not stall.
Assure us all a dealing kind,
Sage potentates with patient skill,
Salubrious state in body and mind,
Sagacious doctors when we're ill.
  Strong family ties give to our life,
  Stalwart, true strength in any strife -
Season delights with cheer and thrill.
"SUMMUM BONUM SALUS ET PAX".

JOHN J. ALIFANO SR., M.D.

DECEMBER 1979 VOL.XXXV-NO.10

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The official bulletin
for The Hampden District
of The Massachusetts
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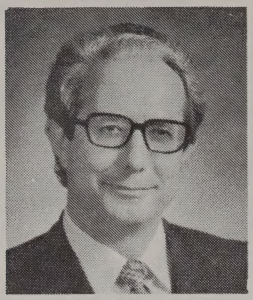

PRESIDENT'S PAGE

Living With HMO's

Until now we have been reading about HMO's, hearing about HMO's, debating about them, discussing a propos of them and finally they are here. Valley Health was the first HMO organized as such in this part of the State, followed by Medical West (Chicopee) sponsored by the ''Blues'' and this while at least two other HMO's are in the planning and development phase. More recently a Western Massachusetts Health Care Foundation has become operative after 4 or 5 years of planning and with the backing of Massachusetts Mutual Life Insurance Company may very well be active as an open panel IPA (Independent Practice Association) in the early part of 1981.

How is the Medical Society looking at the phenomenon? Well, if the quality of care is excellent and the cost containment effective the look is not negative. Still we feel as our duty to provide our members and physicians in general with some kind of directives. HMO's, for instance, contract with physicians in 3 different ways: 1) The Staff Model according to which MD's are employed on a salaried basis; 2) The Group Model whereby contracts are provided to one or more medical groups to deliver Care on prepaid per capita basis and 3) The IPA model where contracts are signed with an Individual Practice Association whose MDs are generally reimbursed on a fee-for-service basis. Group Model and IPA model are seen as more respondent to the spirit of medical freedom which so many of us still equates as a necessity for top quality of medical delivery. In any event a 1978 National Chamber of Commerce study suggests equal or better level of care in the HMO system then in the traditional one. Definite criticism on our part is directed at these two points: 1) According to some studies medical care in HMO's develops a tendency to become too skimpy, too limited, and 2) most of the statistical studies,revealing a significant cost containment in populations covered by HMO's, are biased as too many HMO's ''skim'' by enrolling employees and families who require considerably less hospitalization than the poor or elderly.

Our society approves the concept of neutral public policy and the fair market competition among all systems of health care delivery but

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we should, here as well as nationally, create a fact gathering project to check HMO's impact on access, quality and cost of health care.

Looking then at the health care system of tomorrow in our District (and possibly on a National level as well) it may consist of three parallel and competing channels of delivery: the private physician, the Individual Practice Association (IPA) and the HMO. The bulk of health-care delivery 10 years hence will still be the private physician, though more and more the solo practitioner will give way to the group practices. The IPA may very well be next in importance. Certain employers in our area will get together and set standards and fees for medical services with the help of a medical director or counselor. Physicians who agree to meet the standards and fee levels will be recommended to employees by the IPA. This is essentially the system that has been working well in Germany for 75 years. It preserves freedom of choice on the part of the patient but also provides a mean of cost and quality control. Personally I think that standard HMO's will continue to grow only to the extent to which government imposes them, being an idea whose time has passed despite fervent advocates in Washington. The IPA does everything the HMO does but without the latter's limitations - that is, the absence of physician choice and a permanent physician-patient relationship. The great cost-advantage of standard HMO is its ability to concentrate its patients in one centrally managed health care facility. In a decentralized country like ours this isn't an advantage at all.

From my point of view the great attraction of an IPA is that policing of standards will stay within the medical fraternity. On a more national spectrum the formation of HMO's as a cost containment mechanism and vechicle for integrated health care is politically powerful especially at a time when citizens, industry and government are all attacking physicians and hospitals as scapegoats to blame for inflation. The pressures of government toward cost containment in health care need no emphasis. However, the national debate on a balanced budget, the inflation spiral, the Kennedy-Carter rivalry, and other factors provide the private sector some time to demonstrate effective alternatives to National Health Insurance and/or mandatory wage price controls. Successful HMO-IPA projects may contribute an effective component to liberalize the principle of an eventual national health care program. □

FRANCO NAVAZIO, M.D.
President, H.D.M.S.

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A Promising Future For Private Practice

For nearly a decade, there has been an increasing interest on the part of the public, employers, government and the medical community in finding alternatives to traditional forms of health insurance and health care delivery systems. The Health Care Foundation of Western Massachusetts, formed in 1972, has been the physicians organized response to this concern.The Foundation has actively studied various HMO approaches over the past seven years with the help of actuarial consultants, demographic analyses and marketing research. It has identified one approach which preserves the best of the current health care system and meets the interests of physicians and their patients alike. The HMO maintains free choice of a personal physican who will continue to practice from his own office; preserves the individual patient/physician relationship; is free from governmental involvement; and provides a comprehensive prepaid health care program for the people of Western Massachusetts.

On November 7, 1979, I was privileged to join James R. Martin, Chairman of the Board of the Massachusetts Mutual Life Insurance Company, to announce that our two organizations have agreed to jointly develop this unique HMO program. The agreement has been formalized in a Memorandum of Understanding between the Massachusetts Mutual Life Insurance Company and the Health Care Foundation of Western Massachusetts which provides for the establishment of a new HMO corporation. Within this document are provisions for Health Care Foundation members to serve on the Board of Directors of the new corporation. It further provides that the Foundation shall have primary responsibility for the medical affairs of the HMO prograam and that Massachusetts Mutual will provide certain administrative support services. This agreement between a major insurance company and a regional physicians organization to jointly develop this HMO is unique. It is the first of its type in the entire country and has been made possible by a high degree of mutual trust and respect that has evolved between these two organizations.

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When operational, the HMO will be characterized by a "Primary Care Physician Network" - a variation of the more traditional "open panel" HMO model. The HMO will seek contractual relationships with primary care physicians practicing throughout the region. Under this program, primary care physicians are those physicians in private practice who agree to assume complete responsibility for the total health care needs of their HMO enrolled patients. Upon enrolling, each HMO subscriber will select a personal primary care physician and will agree to initially channel all non-emergency medical care needs through that physician. Medical care that is not provided directly by the patient's personal physician will be referred to appropriate medical and/or surgical specialists. The primary care physician will have total freedom to refer his or her patients to any specialist for necessary care. Moreover, reimbursement levels for primary care as well as specialty care will be kept current. The Health Care Foundtion through various peer review activities will assure high quality of care, appropriateness of referrals, as well as appropriate utilization. Health care services provided through this HMO will be covered in the physician's private office, hopsital, the patient's home, or any other appropriate setting.

Earlier this year, Foundation staff randomly contacted over fifty (50) practicing primary care physicians in Western Massachusetts to test physician interst in the "Primary Care Physician Network" concept. The results of this survey were extremely encouraging. Every physician contacted expressed either a desire to contract immediately or had a serious interst in particpation once the program was developed. Because of this strong support, Massachusetts Mutual and the Foundation agreed to execute the Memorandum of Understanding and to proceed with developmental activities.

Now that the formal announcement has been made, the Foundation will be working closely with Massachusetts Mutual to prepare the required application for state licensure. We expect the application to be submitted to the State by the end of January. Following the State's review, which is expected to take two to three months, the HMO corporation will be established.

Membership in the Health Care Foundation of Western Massachusetts will not be a requirement for physician involvement in the HMO. However, during the coming months, physician contributions will be vital to the final design of the HMO program. Members of HMO working committees or "task forces" will be drawn from Foundation membership. Therefore, practicing physicians who are not currently Foundation members are urged to become members of the Foundation and help shape this exciting program. The one-time $100 tax-deductible membership fee can be used by the Foundation to assure its ongoing role in the day-to-day developmental activities of the HMO.

The success of this HMO depends on the continuing support and the involvement of the medical community. Once the HMO is operational, our patients can take advantage of a truly comprehensive and convenient system of quality health care delivery without interruption of existing physician/patient relationships; a goal we have all long supported. □

ROBERT A. SEARS, M.D., PRESIDENT
Health Care Foundation of Western Massachusetts, Inc.

Mass. Mutual and Health Care Foundation To Launch HMO

On Monday, November 5, 1979, final agreement on a mutual working relationship to develop and operate a unique open-panel HMO program was reached between Massachusetts Mutual Life Insurance Co. and the Health Care Foundation of Western Massachusetts, Inc. The HMO will preserve the private practice of medicine, maintain existing physician/patient relationships, will be office, not clinic, based and will take maximum advantage of existing health care resources. This relationship has been translated into a "Memorandum of Understanding" which I signed on behalf of the Massachusetts Mutual and Dr. Sears signed on behalf of the membership of the Health Care Foundation. Mass. Mutual's plans to work with the Foundation to organize, deliver and finance comprehensive health care services initially to employed groups and their dependents is considered to be an exciting new venture and one, with the help of the medical community, which will be beneficial to physicians and their patients alike.

The Massachusetts Mutual has been impressed by the record of the Foundation in developing innovative approaches to the review of quality and appropriateness of medical care provided throughout Western Massachusetts. The strength and integrity of the Foundation's physician leadership, and their ability to communicate with practicing physicians throughout the region, will make a vital contribution to the program's success.

ROBERT A. SEARS, M.D.
JAMES R. MARTIN
"MEMORANDUM OF UNDERSTANDING"

The HMO corporation will be an independent subsidiary of the Massachusetts Mutual and will be governed by a Board of Directors consisting of representatives of both the Massachusetts Mutual and the Health Care Foundation. I believe that in the development and operation of this program, the experience and ideas of the physician community are best served by formal representation at the HMO policy-making level. While many legal, medical and administrative prerequisites must be met if the HMO is to begin its marketing and enrollment activities in the fall of 1980, the ongoing cooperation between the two organizations can only help in achieving that goal.

The Massachusetts Mutual is committed to finance the start-up and operational costs of the HMO until the Plan breaks even. We will provide necessary re-insurance to protect the Program's fiscal solvency should unexpected catastrophic medical problems occur which might financially cripple the developing plan during its early years.

From Mass. Mutual's perspective, a significant feature of this HMO will be the enhanced role of physicians who practice primary care. Under the primary care network concept, they become, in essence, general managers of their patients total health care needs. Another attractive feature of this HMO approach is the patient's freedom to continue seeing a "personal physician" of choice, providing that he/she is associated with the HMO. The groups who select the HMO option to their current health insurance coverage will be guaranteed truly comprehensive health care services. The HMO will be offered at competitive rates, making it an attractive option to existing health insurance programs.

The Massachusetts Mutual Life Insurance Co. was founded in May 1851 and has completed 128 consecutive years of business. It is the 10th largest life insurer among over 1800 life companies in the United States and has assets of $7.6 billion. In a letter to Mass Mutual employees in November, I indicated that the company anticipates making the HMO plan available to home office employees on an optional basis as an alternative to the current Mass Mutual health insurance plan that is currently provided to them.

During the formal press conference which was held at the Massachusetts Mutual on Wednesday, November 7th, Dr. Sears made an extremely important point which I believe bears repeating. "The medical community and the public will find this program attractive since it preserves existing patient/physician relationships as well as demonstrates that private initiative can effectively deal with health care delivery issues without govenment intervention." I share Dr. Sears' views entirely and want all physicians to know that it is our plan to develop and operate this program with no direct governmental subsidies, loans or other types of federal or state financial assistance. □

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JAMES R. MARTIN
Chairman of the Board
Mass. Mutual Life Insurance Co.

What's New In Public Health

What's new in the Department of Public Health is a clearer sense of role within the Commonwealth's medical world to make the department more productive and effective in its impact upon the health of the Commonwealth.

The Department of Public Health has four major missions:

1. To protect the public health through disease and illness prevention and encouragement of self-responsibility for good health;

2. To provide health services to specific populations;

3. To insure that proper standards of quality are maintained in the delivery of health care;

4. To insure that adequate health care resources are reasonably available to the public at the lowest reasonable aggregate cost.

Medical treatment has advanced tremendously in the last years as have the number of skilled treatment providers in the Commonwealth. Although progress in treating the ill is still needed, a new set of problems is facing Massachusetts, such problems as adverse health effects from environmental or technological hazards. The Department of Public Health must redefine its own momentum to meet these increasing health needs while reducing its efforts in areas that are being met by other health resources.

Therefore, while our missions remain the same, our program emphasis will be in disease prevention and health protection. This ranges from advocating lifestyle changes that are known to lessen chances of serious disease to determining necessary environmental health standards. In addition to improving the Commonwealth's health, new emphasis in illness prevention and health protection will also contribute to cost containment by reducing the number of serious expensive illness.

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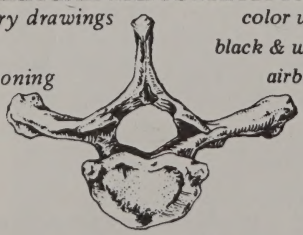
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The Department of Public Health proposes to expand programs as necessary to attain its goals. For example, the Department will expand its radiation health program to monitor presently uncovered radiation sites. The environment is containing an increasing number of commerical reactors, research reactors, and industry and hospital-used radioactive materials. The department aims to prevent unnecessary disease and death from excessive exposure to radiation through strict monitoring and guidelines.

We plan to work closely with the Massachusetts Department of Environmental Quality Engineering (DEQE) to assess the health effects of hazardous wastes in public water supplies. Our water supply is one of the Commonwealth's most valuable resources, yet many towns and cities are experiencing water system closures due to unnecessary chemical pollution. Standards must be determined and effectively maintained.

With the coming budget, the Public Health Department proposes to increase its regional health offices. By adding more personnel and increasing Central Office committment to the regional offices, we aim to improve communication and cooperation with local health agencies. The department will strive to be more responsive to enforcing the sanitary code, to regionalizing home health care agencies, and to improving school health and immunization programs among other local health needs.

We are increasing our committment to the childhood lead prevention program. We hope to replace lead inspectors previously financed by CETA funding with state funds. Through stronger effort to identify children with elevated lead paint levels and to seek houses still containing lead based paint, the department hopes to avert the certain brain and other physical damage that is known to be associated with elevated blood levels in children six years and younger.

The department is strongly concerned about the under immunized late-adolescent, college-age female population that is still susceptible to Rubella, commonly called German Measles. By lessening the chance of Rubella, we can prevent possible retardation in the child, and decrease recent Rubella outbreaks in hospitals and schools.

These are only some of the new program directives that the Public Health Department is planning for future programming. We hope to finance our goals by continued use of available federal funding for services to specific populations, to increase collection of payments both from third party insurers and from clients themselves by using new policies of financial eligibility, and to better utilize state dollars.

With strong emphasis on preventive medicine and health protection programming, the department intends to redirect its available resource to programs that will have the most positive long-term impact on the public health in Massachusetts. □

ALFRED L. FRECHETTE, M.D.
Commissioner of Public Health
Commonwealth of Massachusetts

Public Relations and Ethics

A few weeks ago members of the Editorial Board received a message from Vivian asking for articles for the forthcoming December issue of the Hippocrat. She stated that the issue was originally to be devoted to "Public Relations and Ethics". That phrase, "Public Relations and Ethics", suddenly sprang out of the page and made me think hard. All of a sudden it was very clear. Ethics and Public Relations are so closely interwoven as to be inseparable.

Ethical behaviour by all concerned would allow no need for Public Relations activities. However, that works both ways, as much for those who are rendering service as for those who are receiving services. If all members of a service group always behaved in an ethical manner, there should never be any legitimate criticism directed at them since there would be no substantial cause for criticism. Of course there would always be a small number who would complain about imagined or very minor infractions no matter how angelic the profession comported itself.

But human nature being what it is, ethical behaviour is not always attained. There are misunderstandings, lack of proper communication, inconsiderate acts, and/or statements and other unfortunate occurrences that lead to unhappiness in physician-patient relations.

It has often been stated that good public relations begins in the doctor's office. By efficient and thoughful booking of appointments, avoiding long delays in the physicians waiting room, attention to considerate telephone communication and response, and in many other ways, the physician can maintain a healthy relationship with those requiring his care and treatment. By a willingness to discuss health problems before and after treatment, by cooperation in discussing fees and costs of treatment, and by constant attention to details that might aggravate on-going relationships,the physician can avoid unpleasant situations that reflect on the entire profession.

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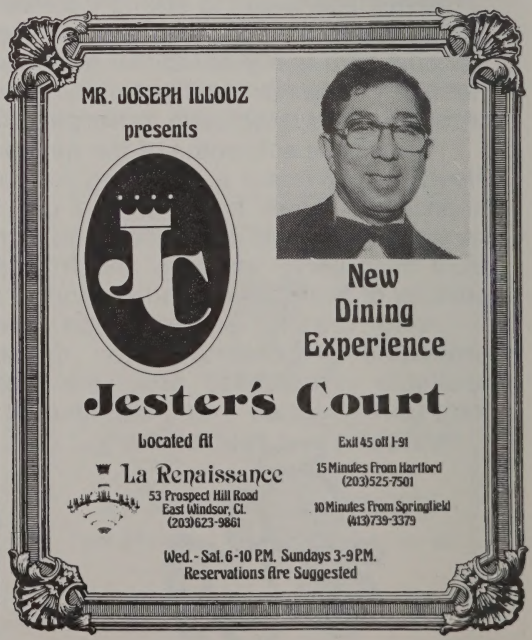

Other aspects of public relations concerns the physicians image outside the treatment room. This includes the profession's willingness to volunteer their services inthe public good and in community affairs. Cooperation in immunization programs, availability in times of need, responding to emergencies - everything which conveys the sincerity and desire on the part of the profession to contribute in every way possible to the health of patients in particular, and the entire community in general.

Were all the above niceties and courtesies practiced routinely by all of us, there would be little need for public relations committees and programs. It can be done, and must be done if the profession is to withstand the abuse and onslaught from many sectors of our society. Anti-professionalism is aimed at many professional groups today; the medical profession has always been an easy target. By our working together in a thoughtful and truly ethical manner we can preserve the high esteem the profession has enjoyed over many decades of scientific and humantarian medical service.

There are those who feel the HDMS should employ a full-time Public Relations expert to handle the problems that arise with the public, press and electronic media. Some might argue that the cost, even if it meant an assessment of each member, or a substantial raise in the fees, would be well worth the expense. As time goes on I see less and less need for paid experts, and more and more need for individual responsibility toward the group and its public image. We all must realize that unpleasant impressions produced, reflect on us all. Whether it is an outrageous fee, a sullen, un-cooperative attitude, inattention to the patients needs, or whatever, remember that the entire profession suffers from these acts, overt or inadvertant. We must practice by the Golden Rule in all our professional and personal activities. We should not have to pay for the thoughtless acts of the few who tarnish our good reputations. All the Public Relations experts in the world can not undo unfavorable and other unpleasant and lasting impressions. □

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The Role of the Trustee in the Delivery of Health Care

At the outset I want to corral the topic of this article into a much narrower focus than the title suggests, because there are many roles played by the trustees of the hospitals in this community. I won't attempt to discuss all the roles, and I don't expect all trustees to agree with me on all points I make -- but I don't expect broad disagreement either.

In some respects the roles of trustees in the delivery of health care have been eroded like a riverbank upstream, and redeposited in a different form downstream. The force behind this erosion and restructuring has been the government, both state and federal, which in turn has been reacting to public opinion that has been concerned with the high cost of health care, and the quality and quantity of health care being conveniently available to all.

Frankly, in years past, government stole a march on us, the trustees, and took over or redirected our roles through such legilation as created PSROs, HSAs, and the like in these instances, the government usurped or greatly intervened in the traditional functions of the trustees in evaluation and planning. Parelleling these legislative actions, were court decisions, that held, at the same time, that trustees were indeed legally responsible and liable for establishing, for example, systems of quality review in their own hospitals.

Caught in this pincer, one's view of the trustee's overriding role becomes clear. He or she is the local person who has ultimate legal responsibility for ensuring that high quality medical care is available when needed and where needed in our community. But I don't want to dwell on the cold, legal aspects of the trustee's role, because if meeting the letter of the law were all that mattered, bureaucrats could easily supplant trustees and no one would notice the difference.

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But there is a difference. We are local people who make up the boards of trustees of our local health care organizations. I live in Springfield; I deal every day with the business, educational and artistic aspects of our community, and so does my family. The point is that what I and other trustees do as trustees, we do to and for ourselves and our families. We don't operate in a vacuum, we are not islands separate unto ourselves. This means we listen carefully, think carefully, and do our homework carefully in order to get the best and most appropriate health care services and facilities for ourselves and our community.

Now, I have stressed a kind of self-interst in all of this in order to lay the ground work for my next observation on the roles of the trustee. I've already tried to give you the answer to "what's-in-it-for-me," because it's a question to be expected when I tell you that one of the other roles of the trustee is to be able and willing to work like a horse; able and willing to devote long, concerted hours dealing with tough questions that have no simple solutions. There is no tangible reward for this effort--no pay, no applause. But there is the ultimate satisfaction of knowing that you have given a significant part of your inner self in behalf of the community of which you are a part.

When any organization that is directed in trust in behalf of the community, whether a hospital, school or church organization, is sufficiently well thought of to attract to its board of trustees such persons who have at heart a sense of community and a committment to work industriously for the organization in behalf of the community, that organization is well on its way to success. In my analogy of the erosion of the riverbank, I alluded to the dynamics of change in the health care field and that flow that has become a flood.

It will be enough for me to repeat in general terms that change has swept in wave after wave through the medical profession in the past ten years. Medicine, of course, is not alone. Our economy has changed, our energy base has changed, and so on. But in our community, in the delivery of health care, only one group in our population has both the legal responsibility and the broad community sensitivity to effect meaningful change. This group is not the medical staffs of the area's hospitals, nor the administrators and managers of those hospitals, not even the patients and potential patients. The responsible group is made up of those persons who are members of the various hospital boards of trustees. In other words the buck stops where it has to stop, by virtue of law and community tradition.

I feel as though I have hit all around the edges of this topic of the trustee's roles in health care delivery.That's probably because, as I indicated at the outset, the subject is a vast one, suitable for an academic dissertation. So let me leave you with this incomplete, but appropriate definition of the role of the trustee in the delivery of health care:

The trustee is the person who acts on behalf of the community in orchestrating the changes in the delivery of health care that are necessitated by the dynamic flow of events in our society, including its economy, technology, law and ethics. This role is recognized in law and tradition and is given urgency by the continuing encroachment of a distant government. □

HERBERT P. ALMGREN

Basis Of The Health Care Cost Concern

The cost of health care has been a concern for many years. For instance in 1950, the financial cost of health care was $12 billion or 4.5 % of the gross national product. The estimated cost for fiscal 1979 is approximately $200 billion or around 9% of the gross national product. There are many reasons for this increase in cost. Some of these increases are represented by newer expensive diagnostic and therapeutic instruments and sophisticated specialty procedures and monitoring. Much of the increase is due to increase in hospital employees salaries. 40% of the health care dollar goes for hospital charges. Inflation has caused considerable general increase in expenditures. Whatever the various reasons, the health care expenditure has risen considerably more than that for other goods and services.

In 1965 the federal government passed the Medicaid and Medicare legislation to provide health coverage for non-employed segments of our population, namely the eligible children and the retired. These programs cost $2 billion in the first year and in fiscal 79 expected to cost $48 billion or about 10% of the budget.

Although there have been efforts over many years to provide social coverage of health care costs much like the social security welfare benefits, there have been increased efforts in the 1970's to institute changes in providing financial coverage and also for providing cost control caps. The financial proposals are for coverage through national health insurance with a combination of private insurance carriers and federal government programs. The differences in the proposals are primarily in the matter of extent of the population to be covered in the initial phases of such a program-varying from coverage from catastrophic expenses only to the extreme of mandatory universal coverage. In what form of whether or not legislation is forth coming in the near future, there certainly is a lot of discussion and argument at national levels. I hope to canvass health care view point statements made in the media over the past four years by the major presidential candidates of both parties and present at least a short capsule regarding each candidate and his public statements relating to health care in the forthcoming issues of the **HIPPOCRAT.** □

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Medical Liability and Punitive Damages

Last April, members of the Mass. Chapter, ACS, received a memorandum regarding a new problem in medical liability, namely "punitive damages." The following is a review of the "Wrongful Death" statute, amended and effective in Massachusetts on January 1, 1974. For further details one might wish to read the statute indicated in the last paragraph of the ensuing article. Attention is called to this statute because the memorandum alluded to above stated that there would be no coverage by the JUA for punitive damages awards.

Massachusetts does not recognize the common law doctrine of punitive damages. Although subject to many variations, that doctrine basically authorizes the awarding of non-compensatory damages designed to punish a defendant's conduct where that conduct has been found to be reckless or wanton. Because Massachusetts does not recognize this doctrine, such damages have traditionally not been recoverable in Massachusetts unless specifically authorized by statute.

One statute of significance in many medical malpractice cases that does authorize the awarding of punitive damages is the wrongful death statute which became effective on January 1, 1974. The statute authorized, in addition to the usual compensatory damages, punitive damages "in an amount of not less than five thousand dollars" in cases where the death was caused by "the malicious, willful, wanton or reckless conduct of the defendant or by the gross negligence of the defendant." Therefore, in any death case, whether a medical malpractice case or an automobile accident case, a plaintiff is entitled to punitive damages of at least $5,000 against each defendant whose conduct is found to have been malicious, willful, reckless or wanton or to have constituted gross negligence.

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There is no record of any punitive damages having been awarded in Massachusetts in a non-death malpractice case. However, a few months ago, a substantial award of punitive damages was made in a malpractice case in Western Mass. under the death statute. The jury awarded those damages upon a special finding that the defendant had been "grossly negligent." The case is currently on appeal, and it is not known whether the insurer has disclaimed coverage for the award.

Of course, none of this means that plaintiff's attorneys do not demand punitive damages in complaints even in non-death cases. If a plaintiff's attorney believes that he has a case in which punitive damages could be properly awarded at common law, he is not necessarily unjustified in demanding such damages in his complaint. It is then the responsibility of defense counsel to raise the issue of the propriety of any such award.

It is hard to say whether such demands are becoming more common. Certainly newspapers have given a great deal of publicity to some rather spectacular punitive damages cases in other jurisdictions. In Massachusetts, plaintiff's counsel may also be responding to the provisions of General Law c. 231, S60C, which prohibit the demanding of a specific monetary amount in medical malpractice complaints, by including demands for punitive as well as compensatory damages. □

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In Memoriam

EUGENE WILFRID BEAUCHAMP, M.D.
1899 - 1979

Eugene Wilfrid Beauchamp died at his home in Chicopee on October 30, 1979.

He was born in Chicopee on April 27, 1899 where his father Dr. Joseph O. Beauchamp practiced medicine for many years. He was graduated from Assumption Preparatory School and Assumption College in Worcester in 1919. He received his medical degree from Jefferson Medical College in Philadelphia in 1923. His degree from Assumption was Summa Cum Laude and his medical degree was also presented with honors.

He interned at Jefferson Hospital in Philadelphia and this was followed by extensive study abroad in England, France and Austria. He never ceased to study medicine during his entire professional life and attended professional meetings and read journals daily until his illness started a few months ago.

In 1926 he entered into the practice of medicine and surgery in Chicopee and practiced for fifty-three years in Chicopee and Springfield.

In 1946 he became a diplomate of the American Board of Surgery.

In 1954 he was honored by Assumption College with an honorary degree of Doctor of Science.

Several years ago he became a papal honoree of Pope Paul VI when he was made a Knight of the hOly Sepulchre by Cardinal Terence Cook in St. Patrick's Cathedral in New York City.

Dr. Beauchamp was a fifty-three year member of the Mercy Hospital Staff where he was a senior attending surgeon, chief of surgery and later a consulting surgeon. He was past president of the Mercy Medical Staff and past president of the staff of the Holyoke Soldiers Home and senior surgeon at the Westfield State Cancer Hospital.

He was past president of the Springfield Academy of Medicine and a member of the American Medical Association, the Massachusetts Medical Society and this Society.

He was a member of the American Cancer Society, a fellow of the American College of Surgeons and was past presidnet of the French Speaking Physicians of New England.

He was a veteran of World War I, a fifty year member of the American Legion and a member of the St. Jean de Baptiste Society and Richelieu Club.

He was a member of the Board of Directors of Assumption College and the Security National Bank of Springfield and was a trustee of the Chicopee Saving Bank.

Dr. Beauchamp leaves his wife, the former Marguerite Lapierre, and four sons who are physicians, Dr. Eugene W. Beauchamp Jr. of Longmeadow, Dr. Charles J. Beauchamp of Davis, California, Dr. David T. Beauchamp of Watchung, New Jersey, and Dr. Joseph O. Beauchamp of Naples, Florida, one daughter, Denise B. Archambault of Putnam, Connecticut and 17 grandchildren.

This litany of his honors and accomplishments bears meager testimony to his true greatness as a physician, a surgeon, and a gentleman who traveled the world and labored to make it a better place for man. The fact that all four of his sons became physicians may tell us something about the way he lived and the example he set. □

WILLIAM F. DONOGHUE, M.D.

AUXILIARY NEWS

The Hampden District Medical Auxiliary will hold a Stage West Theatre Party for **Peg O' My Heart** on Friday, January 25 at 8:30 P.M. at State West. Families are urged to attend as this comedy is suitable for all ages, seven to seventy. Jean Medrek, President, hopes members, husbands and children will come together for a family night at the theatre.

The cost of the benefit is $11.00 per person, payable by January 1 and will include theatre tickets plus refreshments with the actors after the performance. The committee includes Betty Rae Poppo, Chairwoman and Co-chairwomen Diane Abbasy, Louise Weiss, Jane Engleman, Norine Bettigole and Carol Yorzyk. Any of the above can be contacted for information. Reservations and checks should be sent to Jane Engleman, 257 Tanglewood Drive, Longmeadow, Mass. 01106 - telephone 567-1551.

Members who have tickets for another performance can exchange the tickets at the theatre after Jan. 10th, for the Jan. 25th performance and send a $5.00 donation per couple to Jane to cover refreshment costs.

Looking forward to a super turnout for a super show! □

In Memoriam

THEODORE D. BILSKI, M.D.

Dr. Theodore D. Bilski, General Practitioner of Westfield died at Noble Hospital on October 24, 1979.

Dr. Bilski was born in Germany and graduated from the University of Munich receiving his M.D. from the same university.

He lived in Westfield for thirty nine years and was on the staff of Noble Hospital. He was a member of the Massachusetts Medical Society, Hampden District, the Springfield Academy of Medicine and the Beth El Temple.

Deepest sympathy is extended from the H.D.M.S. to his wife, family and friends. □

Letter to the *Managing Editor*

If you were intrigued by the health promotion profile on Kathy Lovell reprinted in the October issue of the Hampden Hippocrat, you might like to know more about Lifeways' **Health Promotion Sampler** and where you can find it.

Through the cooperation of the Western Regional Public Library system copies of the **Sampler** have been placed in all 150 local libraries and branches in the four western counties. The Hampden District Medical Society library also has a reference copy.

The concept underlying the **Sampler** is based on two major principles of community health education. People are more likely to pay attention to and use information from local sources. And people need more than information to motivate healthful behavior.

The **Sampler** is full of practical advice for "how-to" incorporate healthful behavior into daily living and includes ideas for community action as well as information about health issues.

The **Sampler** contains more than forty articles on health promotion, nutrition, fitness/well-being, our environments, attitudes /habits, and disease prevention. Lifeways welcomes reader comments to guide planning for future publications. □

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Letter To Editor

Vivian M. Purdy, Managing Editor
Hampden District Medical Society
1414 State Street
Springfield, MA 01109

Dear Mrs. Purdy:

I read in the November edition of the **Hampden Hippocrat** the reference to Mr. Rand Gesing's presentation to the Society during its first district meeting for the 1979-1980 year. You note that Mr. Gesing proposed cooperation (with the medical community) in discussing cost accounting in an effort to reduce costs of medical care. That sentence was followed by "The program set up by the Planning Council regarding second opinions has already reduced operations fifty percent (50%) in those categories designated for study. The correct reference to this last statement should have been the Health Care Foundation of Western Massachusetts.

For your information, the specific figures concerning the eight (8) elective surgical operations performed on Medicaid patients between 1976 and 1978 are as follows:

ELECTIVE SURGERY RATE AT 1,000 MEDICAID RECIPIENTS

1976, 1978

HCFWM Region

	1976[1] RATE	1978[2,3] RATE	% CHANGE
Tonsillectomy & Adenoidectomy	11.0	4.36	-60
Hemorrhoidectomy	.49	.19	-61
Cholecystectomy	1.3	1.36	+5
Hysterectomy	3.1	1.77	-43
Disc Surgery/Spinal Fusion	.29	.30	+3
Joint Surgery/Menisectomy	.81	.30	-63
Sub-Mucous Resection/Rhinoplasty	.67	.68	+1
Excision of Varicose Veins	.55	.26	-53

1. From DPW Survey, 1976 CHAMP Data
2. From WMPSRO Data, 1978. Number of elective procedures reported as principal procedures.
3. Medicaid population for 1978 is 92,587 for the western Massachusetts welfare region (Office of Research and Data, Massachusetts Department of Public Welfare).

I appreciate your bringing this correction to the attention of the membership.

Sincerely yours,

CHARLES E. EVERETT
Executive Director

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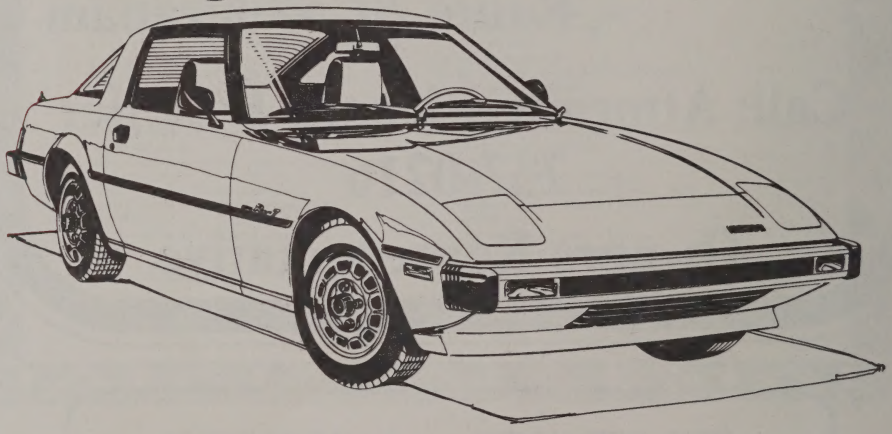

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